MIAMIBEACH

2022/23 Annual Open Enrollment Change Form

Dental Only Retirees

This form is due by Wednesday, August 31, 2022 ONLY IF CHANGES ARE BEING MADE

Coverage Effective Date: October 1, 2022

General Information	
Last Name First Name	MI
Social Security Number Date of - - Daytime Phone Evening Street Address	Birth (MM/DD/YYYY) Gender /
City State Zip Code	Date of Retirement (MM/DD/YYYY)
Dental – Please elect your changes below	
DHMO Office #	Coverage
Dependent Information	
Please enter information for each dependent you wish to enroll for coverage. You mus	at provide proof of dependency and the social security
number of each dependent. Dependents will not be enrolled if this information is missing	
1. Dependent Information	
Last Name First Name	MI
Social Security Number Date of Birth (MMDDYYYY)	Relationship: Spouse Child Other
Gender	
DHMO Office Number (DHMO plan only)	Current Patient? Yes No
2. Dependent Information	
Last Name First Name	MI
Social Security Number Date of Birth (MMDDYYYY)	Relationship Spouse Child Other
Gender	
DHMO Office Number (DHMO plan only)	Current Patient? ☐ Yes ☐ No

3. Dependent Information First Name Last Name MΙ Social Security Number Date of Birth (MMDDYYYY) Relationship: Spouse Child Other Gender ∃Female ∃Male DHMO Office Number (DHMO plan only) **Current Patient?** ☐ Yes \square No 4. Dependent Information Last Name First Name MΙ Social Security Number Date of Birth (MMDDYYYY) Relationship: Spouse Child Other Gender □ Female Current Patient? DHMO Office Number (DHMO plan only) ☐ Yes \square No **Compensation Reduction Agreement** I agree that my pension payment will be reduced by the amount of my required contribution for the benefit option(s) I have elected. The amount of my required monthly contributions for each benefit option I have elected has been provided to me by Human Resources. I also understand the following: I understand I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next Annual Open Enrollment, unless I have a qualified change in family status (qualified life event) such as the birth or adoption of a child, marriage, divorce, death of my spouse, a reduction in hours, or termination of my spouse's employment will notify Employee Benefits within 45 days of the qualifying event to make any necessary changes to my elected coverage. I also understand documentation will be required for verification. If my required contributions for my elected benefits are increased or decreased while this agreement remains in effect, my pension payment will automatically be adjusted to reflect the increase or decrease in premium. The Plan Administrator may reduce or cancel the amount of my payroll contributions or otherwise modify this agreement if the Administrator believes it is advisable in order to satisfy provision or changes in the provisions of the Internal Revenue Code. I am responsible for the associated contributions for the dental benefit coverage I elect, and understand my coverage elections may be terminated should my pension payment be reduced to a level insufficient to cover the cost of my elected dental coverage. I understand that any misrepresentation of the eligibility of my dependents may result in my loss of eligibility under the City of Miami Beach Dental Plan. Signature **Retiree Signature** Date